

Study ID#: _____

Date of Interview: /__/_/ /__/_/ /__/_/_/_/
(Month) (Day) (Year)

Interviewer: _____

MEDICAL AND REPRODUCTIVE HISTORY QUESTIONNAIRE

(PERSONAL MEDICAL HISTORY)

OF THE

BREAST CANCER COMPREHENSIVE PROJECT

Prepared for the National Action Plan on Breast Cancer
of the Office on Women's Health
U.S. Department of Health and Human Services

by

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PERSONAL MEDICAL HISTORY

INTRODUCTION: These next questions ask about certain tests, diseases, conditions, and surgeries you may have had.

Q1. Before (REFERENCE DATE), how long had it been since you had a routine check-up by a doctor or other health care provider? (DO NOT READ CODE RESPONSE)

NEVER	0
LESS THAN ONE YEAR BEFORE (<u>REF DATE</u>)	1
AT LEAST ONE YEAR, BUT LESS THAN TWO YEARS BEFORE (<u>REF DATE</u>)	2
AT LEAST TWO YEARS, BUT LESS THAN THREE YEARS BEFORE (<u>REF DATE</u>)	3
AT LEAST THREE YEARS, BUT LESS THAN FOUR YEARS BEFORE (<u>REF DATE</u>)	4
FOUR OR MORE YEARS BEFORE (<u>REF DATE</u>)	5

Q2. Six months before (REFERENCE DATE), did you ever have a pelvic exam? (PROBE)

YES	1
NO	5 (Q5)

Q3. Did you have (this/these) pelvic exam(s) because of a:

	<u>YES</u>	<u>NO</u>
routine health care visit, including a Pap smear?	1	5
follow-up of previous gynecologic problems?	1	5
new gynecologic symptom?	1	5
medical problem, not gynecologic?	1	5
pregnancy check-up?	1	5
prescription for birth control pills, shots, or implants?	1	5
prescription for some other type of birth control, such as IUD?	1	5
prescription for female hormones, but not for birth control?	1	5
menopause		
or because of another reason? (SPECIFY: _____)	1	5

Q4. How many pelvic exams did you have before (REFERENCE DATE)?

/____/____/
(# OF EXAMS)

MEDICAL CONDITION	Q5. Before (<u>REFERENCE DATE</u>), did a doctor or other health care provider ever tell you that you had (<u>a.-I</u>):	Q6. In what year did a doctor or other health care provider first tell you that you had (<u>a.-I</u>)?	Q7. Did you ever have treatments for this condition, including hospitalization, surgery or medication?
a. hypertension or high blood pressure?	YES 1 NO 5 (Q5b)	/ _ / _ / _ / _ / (YEAR)	YES 1 NO 5
b. myocardial infarction or heart attack?	YES 1 NO 5 (Q5c)	/ _ / _ / _ / _ / (YEAR)	YES 1 NO 5
c. any other types of heart disease?	YES (SPECIFY: _____) 1 NO 5 (Q5d)	/ _ / _ / _ / _ / (YEAR)	YES 1 NO 5
d. stroke?	YES 1 NO 5 (Q5e)	/ _ / _ / _ / _ / (YEAR)	YES 1 NO 5
e. high cholesterol?	YES 1 NO 5 (Q5f)	/ _ / _ / _ / _ / (YEAR)	YES 1 NO 5
f. migraine headaches?	YES 1 NO 5 (Q5g)	/ _ / _ / _ / _ / (YEAR)	YES 1 NO 5
g. peptic, stomach, gastric, or duodenal ulcer?	YES 1 NO 5 (Q5h)	/ _ / _ / _ / _ / (YEAR)	YES 1 NO 5
h. epileptic seizures?	YES 1 NO 5 (Q5i)	/ _ / _ / _ / _ / (YEAR)	YES 1 NO 5

MEDICAL CONDITION	Q5. Before (<u>REFERENCE DATE</u>), did a doctor or other health care provider ever tell you that you had (<u>a-I</u>):	Q6. In what year did a doctor or other health care provider first tell you that you had (<u>a.-I</u>)?	Q7. Did you ever have treatments for this condition, including hospitalization, surgery or chemotherapy, other medication, or radiation?																																																																																
I. cancer?	<p>Yes 1 (Q5A)</p> <p>No 5 (Q8)</p> <p>Q5A. Were you diagnosed with:</p> <table border="0"> <thead> <tr> <th></th> <th><u>YES</u></th> <th><u>NO</u></th> </tr> </thead> <tbody> <tr> <td>a. Breast cancer?</td> <td></td> <td>15</td> </tr> <tr> <td>b. Ovarian cancer?</td> <td>1</td> <td>5</td> </tr> <tr> <td>c. Cervical cancer?</td> <td>1</td> <td>5</td> </tr> <tr> <td>d. Uterine cancer?</td> <td>1</td> <td>5</td> </tr> <tr> <td>e. Another cancer of the female genital organs?</td> <td></td> <td>15</td> </tr> <tr> <td>f. Colon cancer?</td> <td>1</td> <td>5</td> </tr> <tr> <td>g. Melanoma?</td> <td>1</td> <td>5</td> </tr> <tr> <td>h. Lung cancer?</td> <td>1</td> <td>5</td> </tr> <tr> <td>I. Another (SPECIFY: _____)</td> <td>1</td> <td>5</td> </tr> </tbody> </table>		<u>YES</u>	<u>NO</u>	a. Breast cancer?		15	b. Ovarian cancer?	1	5	c. Cervical cancer?	1	5	d. Uterine cancer?	1	5	e. Another cancer of the female genital organs?		15	f. Colon cancer?	1	5	g. Melanoma?	1	5	h. Lung cancer?	1	5	I. Another (SPECIFY: _____)	1	5	<table border="0"> <tbody> <tr><td>a.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td>b.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td>c.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td>d.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td>e.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td>f.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td>g.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td>h.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td>I.</td><td>/ _ / _ / _ / _ /</td></tr> <tr><td colspan="2">(YEAR)</td></tr> </tbody> </table>	a.	/ _ / _ / _ / _ /	b.	/ _ / _ / _ / _ /	c.	/ _ / _ / _ / _ /	d.	/ _ / _ / _ / _ /	e.	/ _ / _ / _ / _ /	f.	/ _ / _ / _ / _ /	g.	/ _ / _ / _ / _ /	h.	/ _ / _ / _ / _ /	I.	/ _ / _ / _ / _ /	(YEAR)		<table border="0"> <thead> <tr> <th></th> <th><u>YES</u></th> <th><u>NO</u></th> </tr> </thead> <tbody> <tr><td>a.</td><td>1</td><td>5</td></tr> <tr><td>b.</td><td>1</td><td>5</td></tr> <tr><td>c.</td><td>1</td><td>5</td></tr> <tr><td>d.</td><td>1</td><td>5</td></tr> <tr><td>e.</td><td>1</td><td>5</td></tr> <tr><td>f.</td><td>1</td><td>5</td></tr> <tr><td>g.</td><td>1</td><td>5</td></tr> <tr><td>h.</td><td>1</td><td>5</td></tr> <tr><td>I.</td><td>1</td><td>5</td></tr> </tbody> </table>		<u>YES</u>	<u>NO</u>	a.	1	5	b.	1	5	c.	1	5	d.	1	5	e.	1	5	f.	1	5	g.	1	5	h.	1	5	I.	1	5
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Q8. Before (REFERENCE DATE), did a doctor or other health care provider tell you that you had a thyroid condition?

YES	1	
NO	5	(Q16)

Q9. What thyroid condition were you told you had? (SHOW CARD #4)

a. Graves' disease	01
b. Hashimoto's disease (chronic thyroiditis)	02
c. Overactive (<u>hyperactive</u>) thyroid	03
d. Underactive (<u>hypoactive</u>) thyroid	04
e. Goiter	05
f. Nodules	06
g. Cancer	07
h. Low metabolism	08
I. Overweight	09
j. Other (SPECIFY: _____)	77
k. Don't know	98

Q10. In what year did a doctor or other health care provider first tell you that you had (THYROID CONDITION)?

/ _ / _ / _ / _ /
(YEAR)

Q11. Did you ever take medication for (THYROID CONDITION)?

Yes	1	
No	5	(Q14)

Q12. Which medication did you take? (SHOW CARD #5)

a. Thyroid USP or equivalent (Levothyroxine, Thyroxine, Desiccated thyroid) (SPECIFY: _____)	1
b. Synthroid or equivalent (SPECIFY: _____)	2
c. Thyroid gland inhibitor (SPECIFY: _____)	3
d. Other (SPECIFY: _____)	4

Q13. For how many months or years altogether did you take (MEDICINE IN Q12)?

/___/___/

MONTHS 1
YEARS 5

Q14. Did you ever have a procedure, such as surgery or radiation, e for (THYROID CONDITION)?

YES 1
NO 5 (Q16)

Q15. Did you have:

	<u>YES</u>	<u>NO</u>
a. Thyroid surgery?	1	5
b. Radioactive iodine treatment?	1	5
c. X-ray or radiation treatment?	1	5
d. Another procedure? (SPECIFY:_____)	1	5

Q16. Before (REFERENCE DATE), did a doctor or health care provider ever tell you that you have diabetes, or high sugar in your blood or urine?

YES 1
NO 5 (NEXT SECTION)

Q17. Did you have diabetes only during pregnancy, or did you have diabetes at other times?

Only during pregnancy, 1
At other times, or 2
Both during pregnancy and at other times? 3

D18. In what year did a doctor first tell you that you had diabetes other than during pregnancy?

/___/___/___/___/
(YEAR)

Q19. Did you ever take prescribe medicine or insulin for your diabetes?

YES 1

NO 5 (NEXT SECTION)

Q20. Did you take?

Pills only,	1
Insulin only, or	2
Insulin and pills?	3
OTHER (SPECIFY:_____)	4

Q21. How old were you when you started taking medication for diabetes?

/__/_/
(AGE)

MEDICATIONS AND PROCEDURES

<p>Q22. Before (<u>REFERENCE DATE</u>), did you ever take any medication for high blood pressure or fluid retention at least <u>once a week</u> for <u>one month</u> or longer?</p>									
		YES		1					
		NO		5		(Q26)			
<p>Here is a list of some of the most commonly prescribed medications taken for high blood pressure and fluid retention. (SHOW CARD #6)</p>									
	Q23. Did you take (1st/2nd/etc., GENERIC OR BRAND MEDICATION) at least once a week for one month or longer?			Q24. What was the month and year when you started taking (1st/2nd/etc., GENERIC OR BRAND MEDICATION) at least once a week for one month or longer?			Q25. For how many weeks, months, or years, did you take (1st/2nd/etc., GENERIC OR BRAND MEDICATION) for one month or longer?		
1ST MED	YES	1		/ / / (MONTH)	/ / / / / (YEAR)	/ / / (#)	WKS	1	
	NO	5 (2ND MED)					MOS	2	
2ND MED	YES	1		/ / / (MONTH)	/ / / / / (YEAR)	/ / / (#)	WKS	1	
	NO	5 (3RD MED)					MOS	2	
3RD MED	YES	1		/ / / (MONTH)	/ / / / / (YEAR)	/ / / (#)	WKS	1	
	NO	5 (4TH MED)					MOS	2	
4TH MED	YES	1		/ / / (MONTH)	/ / / / / (YEAR)	/ / / (#)	WKS	1	
	NO	5 (5TH MED)					MOS	2	
5TH MED	YES	1		/ / / (MONTH)	/ / / / / (YEAR)	/ / / (#)	WKS	1	
	NO	5 (6TH MED)					MOS	2	
6TH MED	YES	1		/ / / (MONTH)	/ / / / / (YEAR)	/ / / (#)	WKS	1	
	NO	5 (7TH MED)					MOS	2	
7TH MED	YES	1		/ / / (MONTH)	/ / / / / (YEAR)	/ / / (#)	WKS	1	
	NO	5 (8TH MED)					MOS	2	
8TH MED	YES	1		/ / / (MONTH)	/ / / / / (YEAR)	/ / / (#)	WKS	1	
	NO	5 (Q26)					MOS	2	
							YRS	3	

Q26. Did you ever take any medication for ulcers, heartburn, or other stomach condition at least once a week for one month or longer before (REFERENCE DATE)?

YES 1
NO 5 (Q 30)

Here is a list of some medications taken for ulcers, heartburn, and other stomach problems.
(SHOW CARD #7)

	Q27. Did you take (1st/2nd/etc., GENERIC OR BRAND MEDICATION) at least once a week for one month or longer?	Q28. What was the month and year when you started taking (1st/2nd/etc., GENERIC OR BRAND MEDICATION) at least once a week for one month or longer?	Q29. For how many weeks, months, or years, did you take (1st/2nd/etc., GENERIC OR BRAND MEDICATION) for one month or longer?
1ST MED	YES 1 NO 5 (2ND MED)	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
2ND MED	YES 1 NO 5 (3RD MED)	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
3RD MED	YES 1 NO 5 (4TH MED)	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
4TH MED	YES 1 NO 5 (Q30)	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3

Q30. Did you ever take any medication for depression, anxiety, stress, or grief at least once a week for one month or longer before (REFERENCE DATE)?

YES 1
NO 5 (Q34)

Q31. Here is a list of some medications taken for severe or intense depression, anxiety, stress, or grief. (SHOW CARD #8) Did you ever take any of these medications at least once a week for one month or longer?

YES 1
NO 5 (Q34)

	Q31. Which one of these did you take (1st/2nd/etc.) ?	Q32. What was the month and year when you started taking (1st/2nd/etc., GENERIC OR BRAND MEDICATION) at least once a week for one month or longer?	Q33. For how many weeks, months, or years, did you take (1st/2nd/etc., GENERIC OR BRAND MEDICATION) for one month or longer?
1ST MED	_____ MEDICATION	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
2ND MED	_____ MEDICATION	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
3RD MED	_____ MEDICATION	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
4TH MED	_____ MEDICATION	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
5TH MED	_____ MEDICATION	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
6TH MED	_____ MEDICATION	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
7TH MED	_____ MEDICATION	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3
8TH MED	_____ MEDICATION	/__/_/ (MONTH) /__/_/_/_/ (YEAR)	/__/_/ (#) WKS 1 MOS 2 YRS 3

Q34. Before (REFERENCE DATE), did you ever take tamoxifen or Nolvadex?

YES	1	
NO	5	(Q39)

Q35. What was the month and year when you started taking tamoxifen or Nolvadex?

/__/__/	/__/__/__/
(MONTH)	(YEAR)

Q36. What was the month and year when you stopped taking tamoxifen or Nolvadex?

/__/__/	/__/__/__/
(MONTH)	(YEAR)

Q37. Before (REFERENCE DATE), for how many weeks, months, or years, total, did you take tamoxifen or Nolvadex? Include only the times you were actually taking the medicine.

/__/__/	WEEKS	1
(#)	MONTHS	2
	YEARS	3

Q38. Before (REFERENCE DATE), how many tamoxifen or Nolvadex tablets did you usually take each day?

/__/__/	PER	DAY	1
(# OF TABLETS)		WEEK	2
		MONTH	3

Q39. Did you take any other prescription medications for **six months or longer** from (TWENTY YEARS BEFORE REFERENCE DATE) to (REFERENCE DATE)? These are medications we have not already discussed.

Yes	1	
No	5	(Q43)

Q40. What is the name of the medication? (Did you take any other medication for six months or longer between [DATES]?)	Q41. How old were you when you started taking (<u>MEDICATION FROM Q40</u>)?	Q42. How old were you when you stopped taking (<u>MEDICATION FROM Q.40</u>)?
a. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
b. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
c. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
d. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
e. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
f. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
g. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
h. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
I. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95
j. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE) CURRENT 95

k. _____ (MEDICATION)	/__/_/ (AGE)	/__/_/ (AGE)
		CURRENT 95

Q43. Before (<u>REFERENCE DATE</u>), did you ever have a physical breast exam by a doctor or other health care provider?	YES 1
	NO 5 (Q45)
Q44. How old were you when you first had a physical breast exam?	
/__/_/ (AGE)	
Q45. Before (<u>REFERENCE DATE</u>), did you ever have a mammogram?	YES 1
	NO (Q49)
Q46. How old were you when you had your first mammogram?	
/__/_/ (AGE)	
Q47. Approximately how many mammograms have you had in your whole life?	
/__/_/ (Number)	
Q48. How old were you when you had your (<u>2nd, 3rd, etc.</u>) mammogram?	
<u>AGE</u>	
2ND	/__/_/
3RD	/__/_/
4TH	/__/_/
5TH	/__/_/
6TH	/__/_/
7TH	/__/_/
8TH	/__/_/
9TH	/__/_/
10TH	/__/_/

Q49. Have you ever had any type of breast surgery or procedure for any reason?

YES 1
NO 5 (NEXT SECTION)

	Q50. What was the (1st/next) procedure or surgery you had?	Q51. In what month and year did you have this procedure?	(IF Q50=04,05,06,07, 08 SKIP TO NEXT SECTION; IF Q50=01,02,03 ASK:) Q52. How was the problem with your breast first discovered?	Q53. Which breast was involved?	Q54. Was cancer found?
1ST	TOTAL REMOVAL OF BREAST 01 CYST REMOVAL, BIOPSY, LUMPECTOMY, PARTIAL REMOVAL OF BREAST 02 ASPIRATION OR NEEDLE BIOPSY 03 IMPLANT SURGERY (TISSUE) 04 IMPLANT SURGERY (SILICONE) 05 IMPLANT SURGERY (SALINE) 06 IMPLANT (TYPE UNKNOWN) 07 REDUCTION SURGERY 08	/__/_/ __/_/_/_/_____ (MONTH) (YEAR) OR /__/_/ (AGE)	ROUTINE SELF-BREAST EXAM 01 ACCIDENTAL SELF-DISCOVERY 02 PARTNER DISCOVERED 03 ROUTINE BREAST EXAM BY DOCTOR OR OTHER PROVIDER 04 ROUTINE SCREENING MGRAM 05 FOLLOW-UP MAMMOGRAM FOR A PRIOR BREAST PROBLEM 06 OTHER (SPECIFY: _____) 07	LEFT 1 RIGHT 2 BOTH 3	YES 1 NO 5 (Q50)
2ND	TOTAL REMOVAL OF BREAST 01 CYST REMOVAL, BIOPSY, LUMPECTOMY, PARTIAL REMOVAL OF BREAST 02 ASPIRATION OR NEEDLE BIOPSY 03 IMPLANT SURGERY (TISSUE) 04 IMPLANT SURGERY (SILICONE) 05 IMPLANT SURGERY (SALINE) 06 IMPLANT (TYPE UNKNOWN) 07 REDUCTION SURGERY 08	/__/_/ __/_/_/_/_____ (MONTH) (YEAR) OR /__/_/ (AGE)	ROUTINE SELF-BREAST EXAM 01 ACCIDENTAL SELF-DISCOVERY 02 PARTNER DISCOVERED 03 ROUTINE BREAST EXAM BY DOCTOR OR OTHER PROVIDER 04 ROUTINE SCREENING MGRAM 05 FOLLOW-UP MAMMOGRAM FOR A PRIOR BREAST PROBLEM 06 OTHER (SPECIFY: _____) 07	LEFT 1 RIGHT 2 BOTH 3	YES 1 NO 5 (Q50)

3RD	TOTAL REMOVAL OF BREAST	01	/___/___/ /___/___/___/ (MONTH) (YEAR)	ROUTINE SELF-BREAST EXAM	01	LEFT 1 RIGHT 2 BOTH 3	YES 1 NO 5 (Q50)
	CYST REMOVAL, BIOPSY, LUMPECTOMY,			ACCIDENTAL SELF-DISCOVERY	02		
	PARTIAL REMOVAL OF BREAST	02	PARTNER DISCOVERED	03			
	ASPIRATION OR NEEDLE BIOPSY	03	OR	ROUTINE BREAST EXAM BY			
	IMPLANT SURGERY (TISSUE)	04		DOCTOR OR OTHER PROVIDER	04		
	IMPLANT SURGERY (SILICONE)	05		ROUTINE SCREENING MGRAM	05		
	IMPLANT SURGERY (SALINE)	06		FOLLOW-UP MAMMOGRAM FOR A			
	IMPLANT (TYPE UNKNOWN)	07		PRIOR BREAST PROBLEM			
REDUCTION SURGERY	08	/___/___/ (AGE)		06			
			OTHER (SPECIFY: _____)	07			

	Q50. What was the (1st/next) procedure or surgery you had?	Q51. In what month and year did you have this procedure?	(IF Q50=04,05,06,07, 08 SKIP TO NEXT SECTION; IF Q50=01,02,03 ASK:) Q52. How was the problem with your breast first discovered?	Q53. Which breast was involved?	Q54. Was cancer found?		
4TH	TOTAL REMOVAL OF BREAST	01	/___/___/ /___/___/___/ (MONTH) (YEAR)	ROUTINE SELF-BREAST EXAM	01	LEFT 1 RIGHT 2 BOTH 3	YES 1 NO 5 (Q50)
	CYST REMOVAL, BIOPSY, LUMPECTOMY,			ACCIDENTAL SELF-DISCOVERY	02		
	PARTIAL REMOVAL OF BREAST	02	PARTNER DISCOVERED	03			
	ASPIRATION OR NEEDLE BIOPSY	03	OR	ROUTINE BREAST EXAM BY			
	IMPLANT SURGERY (TISSUE)	04		DOCTOR OR OTHER PROVIDER	04		
	IMPLANT SURGERY (SILICONE)	05		ROUTINE SCREENING MGRAM	05		
	IMPLANT SURGERY (SALINE)	06		FOLLOW-UP MAMMOGRAM FOR A			
	IMPLANT (TYPE UNKNOWN)	07		PRIOR BREAST PROBLEM			
REDUCTION SURGERY	08	/___/___/ (AGE)		06			
			OTHER (SPECIFY: _____)	07			

5TH	TOTAL REMOVAL OF BREAST	01	/___/___/ /___/___/___/ (MONTH) (YEAR)	OR	/___/___/ (AGE)	ROUTINE SELF-BREAST EXAM	01	LEFT 1 RIGHT 2 BOTH 3	YES 1 NO 5 (Q50)
	CYST REMOVAL, BIOPSY, LUMPECTOMY,					ACCIDENTAL SELF-DISCOVERY	02		
	PARTIAL REMOVAL OF BREAST	02				PARTNER DISCOVERED	03		
	ASPIRATION OR NEEDLE BIOPSY	03				ROUTINE BREAST EXAM BY			
	IMPLANT SURGERY (TISSUE)	04				DOCTOR OR OTHER PROVIDER	04		
	IMPLANT SURGERY (SILICONE)	05				ROUTINE SCREENING MGRAM	05		
	IMPLANT SURGERY (SALINE)	06				FOLLOW-UP MAMMOGRAM FOR A			
	IMPLANT (TYPE UNKNOWN)	07				PRIOR BREAST PROBLEM			
	REDUCTION SURGERY	08					06		
						OTHER (SPECIFY: _____)	07		
6TH	TOTAL REMOVAL OF BREAST	01	/___/___/ /___/___/___/ (MONTH) (YEAR)	OR	/___/___/ (AGE)	ROUTINE SELF-BREAST EXAM	01	LEFT 1 RIGHT 2 BOTH 3	YES 1 NO 5 (Q50)
	CYST REMOVAL, BIOPSY, LUMPECTOMY,					ACCIDENTAL SELF-DISCOVERY	02		
	PARTIAL REMOVAL OF BREAST	02				PARTNER DISCOVERED	03		
	ASPIRATION OR NEEDLE BIOPSY	03				ROUTINE BREAST EXAM BY			
	IMPLANT SURGERY (TISSUE)	04				DOCTOR OR OTHER PROVIDER	04		
	IMPLANT SURGERY (SILICONE)	05				ROUTINE SCREENING MGRAM	05		
	IMPLANT SURGERY (SALINE)	06				FOLLOW-UP MAMMOGRAM FOR A			
	IMPLANT (TYPE UNKNOWN)	07				PRIOR BREAST PROBLEM			
	REDUCTION SURGERY	08					06		
						OTHER (SPECIFY: _____)	07		